Report on:

The Definition and Impact of Specialty Hospitals in Kansas

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The Definition and Impact of Specialty Hospitals in Kansas
Evaluation and Policy Recommendations

Executive Summary

The 2006 Kansas Legislature included a proviso in the appropriations bill for the Division of Health Policy and Finance (now the Kansas Health Policy Authority [KHPA]) that required the agency to:

> …conduct a review and study of the issues relating to specialty hospitals and a review and study of the Kansas licensure laws and to prepare and adopt recommendations concerning these issues and, in particular, appropriate definitions for "general hospital," "special hospital" and "specialty hospital" so that the definitions under the Kansas hospital licensure laws properly define specific categories of hospitals for licensure as necessary to reflect current medical facilities…1

This study provides an overview of the issues associated with the recent introduction of specialty hospitals into health care markets in Kansas. Core issues associated with these new facilities include: the financial impact of specialty hospitals on community, or general hospitals; the impact of specialty hospitals on quality of care; the impact of self-referrals by physician-owners of specialty hospitals; flaws in Medicare reimbursements for procedures typically performed in specialty hospitals; the utility of certificate of need programs and other policy tools that could be used by state policymakers to impede the growth of specialty hospitals; and the appropriate definition of specialty versus general hospitals.

Among the conclusions drawn by this study are the following:

- Much of the growth in specialty hospitals can be attributed to flaws in Medicare payment rules, which allow physician self-referral and provide overly generous rewards for the kinds of services provided by specialty hospitals.
- Physician ownership in specialty hospitals raises troubling questions about the impact of financial incentives on patient care. However, the net impact of physician ownership and self-referral on overall costs and patient care has not yet been firmly established.
- Existing evidence does not clearly indicate whether the harm that specialty hospitals may do to general hospitals and the community services they provide outweighs the value specialty hospitals may add to patient quality and competition.
- State interventions to protect hospital markets and to correctly align physician incentives might best be addressed after the new Congress has a chance to address flaws in Medicare physician and hospital payments.

This study is silent with regard to the appropriate definition of a "specialty" or "general" hospital for purposes of state licensure. There may be inherent public policy value in better distinguishing the general hospitals from other types of hospitals. However, this distinction does not currently bear on payment or regulations that might affect the location, operation, or market impact of facilities commonly referred to as specialty hospitals. This report focuses on evaluating the impact of so-called specialty hospitals on the state, and the key policy levers available to policymakers should they choose to take advantage.

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1 HB 2968 Sec. 35(i)

Specific recommendations that follow from this evaluation include:

I. Recently announced changes to the Medicare In-Patient Prospective Payment System (IPPS) will help address concerns about the relative profitability of services provided in general and specialty hospitals. KHPA should incorporate these changes into its Medicaid inpatient reimbursement rates.

II. In an effort to provide a more transparent system for the funding of hospital services that benefit the community, such as uncompensated care for the uninsured, KHPA should continue its work with hospitals to re-design the Medicaid DSH program to provide a more consistent and better-targeted source of funding for uncompensated care.

III. To monitor the potential impact of specialty hospitals and other facilities on the quality and cost of care in Kansas, data to support ongoing analysis of this impact should be collected and maintained by KHPA.

IV. The potential benefits of specialty hospitals are predicated on the existence of a more competitive and informed marketplace. KHPA recommends a two-phase initiative to provide greater health information transparency for consumers by i) working with Kansas libraries to create a common destination for publicly-available sources of information on health care costs and quality, and ii) working through the Data Consortium to generate new sources of information that can be collated and shared with consumers.

Introduction

The 2006 Kansas Legislature included a proviso in the appropriations bill for the Division of Health Policy and Finance (now the Kansas Health Policy Authority – KHPA) that required the agency to:

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The requirements of this proviso reflect issues and concerns that have recently been raised at both local and national levels regarding specialty hospitals. These concerns, as well as the complexity of the associated issues, have led to a significant amount of investigative analysis at the federal level and the number of studies and research articles published over the past three years. A recent article in *Time* magazine (December 11, 2006), profiling the situation in Wichita, indicates the level of national attention this issue is receiving.

National concern about the impact of specialty hospitals prompted Congress to include an 18-

2 HB 2968 Sec. 35(i)

month moratorium on the approval of specialty hospitals as Medicare providers in the Medicare Modernization Act (MMA) of 2003. The MMA also directed the Secretary of the Department of Health and Human Services (HHS) to complete a study of specialty hospital referral patterns, quality of care, and an evaluation of uncompensated care. In addition, the Medicare Payment Advisory Commission (MedPAC) was directed to prepare a report for Congress on specialty hospitals.

Following the expiration of the moratorium, the Centers for Medicare and Medicaid Services (CMS) suspended the enrollment of specialty hospitals in Medicare until mid-February 2006; however, the suspension was extended six months by the Deficit Reduction Act (DRA) of 2005. The DRA also required HHS/CMS to make another report to Congress examining issues of physician investments and disclosure of such, as well as the provision of care to Medicaid and Medicare patients, and charity care. HHS/CMS presented the final report on August 10, 2006, along with an implementation plan addressing various issues related to specialty hospitals, including Medicare reimbursement changes, sponsoring demonstration projects to promote physician-hospital collaborations, and requiring information from providers on physician investment and compensation arrangements. The suspension of specialty hospital enrollment in Medicare ended at the same time.

KHPA staff reviewed reports, research articles and studies to prepare this report. In addition, we met with Kansas Department of Health and Environment (KDHE) Bureau of Child Care & Health Facilities staff, as well as the author of a Kansas Health Institute (KHI) study commissioned by KDHE (Weisgrau, 2006) on the impact of specialty hospitals in Kansas. State statutes and regulations governing hospital licensure were reviewed, and other states were surveyed regarding their licensing requirements and certificate of need (CON) programs. We also interviewed the former director of the Kansas CON program. Finally, we met with representatives of general hospitals and specialty hospitals, as well as their respective membership organizations (the Kansas Hospital Association and the Kansas Surgical Hospital Association), to learn their perspectives on the issue. We came away from those meetings with renewed understanding of the complexity of this issue.

Kansas currently has eleven hospitals that are generally regarded as specialty hospitals. There are 125 general hospitals in Kansas; 83 of the general hospitals are designated as critical access hospitals (CAH's). Kansas is one of four states (along with Oklahoma, South Dakota and Texas) where almost 60 percent of all specialty hospitals are located (MedPAC, 2005).

Hospital – Definitions and Licensing

While there is no federal licensure of hospitals, most hospitals participate in the Medicare program, so statutes, regulations, and other guidance concerning Medicare apply to any participating hospital. Title 18 of the Social Security Act, which authorizes the Medicare program, defines a hospital as:

> …primarily engaged in providing, by or under supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons…3

3 Section 1861 of the Social Security Act.

Federal regulations governing Medicare specify that any hospital participating in the program "…must be (l)licensed; or (a)approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals."[4] In Kansas, that agency is KDHE. The State can impose any licensing requirements it deems appropriate as long as they are not in conflict with any Medicare statutes or regulations.

The Hospital Manual, Publication 10, published by CMS defines a hospital as "…an institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians"[5] diagnostic, therapeutic, or rehabilitative services. The term "inpatient" is defined as:

> …a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally a person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.[6]

So, for the purpose of Medicare reimbursement, the two critical factors in CMS' designation of a facility as a hospital in Kansas appear to be that it provides care primarily to inpatients and that it is licensed as a hospital though not necessarily a general hospital) by KDHE.

KDHE defines a hospital as "'general hospital,' 'critical access hospital,' or 'special hospital'."[7] A **general** hospital is defined as:

> …an establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds, and with medical services, including physician services, and continuous registered professional nursing services for not less than 24 hours every day, to provide diagnosis and treatment for patients who have a *variety* of medical conditions.[8] *[emphasis added]*

A **critical access** hospital (CAH) is defined in Kansas statute[9] as a member of a rural health network that provides limited inpatient care (25 beds or less), provides 24-hour nursing care whenever there are inpatients, and may use physician assistants, clinical nurse specialist or nurse practitioners – under physician supervision – to provide inpatient care.

There is no category in the Kansas hospital licensing statute for a "specialty" hospital; however, a **special** hospital is defined, by KDHE, as:

> …an establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds; and with medical services, including physician services, and continuous registered professional nursing services for not less than 24 hours every day, to provide diagnosis and treatment for patients who

4 42 CFR 482.11.
5 CMS. Publication 10, Section 200, Revision 479, p. 19.
6 Ibid. Section 210, Revision 559, p. 21.3a.
7 K.S.A. 65-425 (j).
8 K.S.A. 65-425 (a).
9 K.S.A. 65-468 (f).

have *specific* medical conditions.10 [*emphasis added]*

For KDHE licensure, the primary distinction between a general hospital and a special hospital is the breadth of medical conditions the patients in a facility have; however, KDHE does not determine which of the two categories a facility is in, but allows hospitals to self-select. Neither type of hospital is required by Kansas statutes to maintain an emergency department. Kansas statutes also do not make a distinction between the two hospital categories regarding the amount of inpatient care. Examples of special hospitals in Kansas include orthopedic hospitals, heart hospitals, surgical hospitals, rehabilitation hospitals, and mental health hospitals.

Specialty Hospitals in Kansas

The types of hospitals at issue in this report, and that have generated so much policy interest nationally in the last few years, do not coincide with the licensure class of special hospitals in Kansas. A KHI issue brief released in December 2003 observes that:

> "specialty hospitals provide services in a single medical specialty, such as cardiology or orthopedics. These hospitals however are not the same as psychiatric, women's or children's hospitals. Those types of hospitals offer a range of services. They are also different from ambulatory surgical centers, which are restricted by Federal regulation from offering inpatient services, and do not focus on a particular specialty." (Bentley and Allison, 2003)

Typically, specialty hospitals in Kansas do not offer the full range of services that are found in general hospitals. For instance, specialty hospitals do not generally offer emergency department services, nor do they provide obstetrical care.

In addition to the various definitions, specialty hospitals are organized under three basic operational structures: national management chains that partner with local physicians, joint ventures between a general hospital and local physicians, and physician groups that go it alone. In Kansas, 45 percent of specialty hospitals are joint ventures with management companies, 22 percent are joint general hospital-physician operations, and 33 percent are solely physician-owned.

Potential Definitions of Specialty Hospitals

A review of the literature shows multiple definitions of specialty hospitals, and that Federal and states' definitions do not always agree. Definitions also vary across the many studies of specialty hospitals. The General Accounting Office – now known as the Government Accountability Office (GAO) has conducted studies which describe specialty hospitals as those that predominately treat certain diagnoses or perform certain procedures. The GAO (October 2003) classified a hospital as a specialty hospital if "the data indicated that two-thirds or more of its inpatient claims were in one or two major diagnosis categories (MDC), or two-thirds or more of its inpatient claims were for surgical diagnosis related groups (DRG's)." (p.2)

In its report to Congress, MedPAC established these criteria to define physician owned specialty hospitals as:

- "be physician owned,
- "specialize in certain services,
- "at least 45 percent of the Medicare cases must be in cardiac, orthopedic, or surgical services,

10 K.S.A. 65-425 (b)

- "or, at least 66 percent must be in two major diagnostic categories (MDC's), with the primary one being cardiac, orthopedic, or surgical cases." (MedPAC, 2005, p. 4)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), provides this definition of a specialty hospital: "For the purposes of this section, except as provided in subparagraph (B), the term "specialty hospital" means a subsection (d) hospital (as defined in section 1886(d)(1)(B) that is primarily or exclusively engaged in the care and treatment of one of the following categories:

"(i) Patients with a cardiac condition.
"(ii) Patients with an orthopedic condition.
"(iii) Patients receiving a surgical procedure.
"(iv) Any other specialized category of services that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section."11

In its final report and accompanying recommendations, HHS uses a general definition of specialty hospitals containing core elements from the MedPac and MMA definitions: "hospitals exclusively or primarily engaged in caring for one of the following categories of patients: patients with a cardiac condition or an orthopedic condition; or patients receiving a surgical procedure." (CMS Press Release, August 8, 2006)

Certificate of Need

Certificate of need (CON) is an option states may use to regulate excess capacity of health care services. In the 1960's many states had CON laws that required hospitals wanting to add new beds, build new facilities, or expand services to demonstrate an unmet need in the community in order to justify the new facility or service.

In 1974, Congress passed the National Health Planning and Resource Development Act. The Act directed that new health care facilities and additions to existing facilities must be approved by state agencies with programs created to approve certificates of need. The law held that the scope of CON review applied to all health care, not just inpatient hospital beds. States were mandated to have CON programs in place by 1978 or face loss of Medicare and Medicaid funding from the federal government. In 1987, Congress repealed its mandate and stopped subsidizing states that had implemented CON (Choudry, Choudry and Brennan, 2005) because many states had not renewed their CON provisions and allowed their programs to sunset without facing sanction from the federal government. Thirty-seven states now have CON laws, although not all of these states regulate hospital development or expansion (American Health Planning Association, 2005). Some states regulate only long-term care facilities such as nursing homes and intermediate care facilities for people with mental retardation (see Appendix A).

There is a negative correlation between states with CON laws and the establishment of specialty hospitals. The GAO found that about half of the US population lives in states where there are no CON laws, and more than fifty percent of all general hospitals are in those states. Those same states have eighty-three percent of all specialty hospitals (GAO, October 2003). In states where

11 MMA, Section 507, Clarifications to Certain Exceptions to Medicare Limits on Physician Referrals, (B) Definition – Section 1877(h) (42 U.S.C. 1395nn(h)) amended.

CON legislation is enforced, there has been limited growth in specialty hospitals and ambulatory surgical centers (ASC's). Conversely, in Kansas there are no CON laws regulating the development of specialty facilities. Kansas allowed its CON law to sunset in 1985.

KHPA surveyed states that have CON requirements. The results of the survey indicated that, for the responding states, staffing and budgets range from two staff and an annual budget of $40,000.00 to six staff and $1.3 million annual budget. States told us they all have established application processes, collected application fees, and have appeal processes.

CON is considered by critics to be governmentally burdensome and ineffective in controlling costs and improving efficiency. Smith-Mello (2004), in a review of Kentucky's CON program, points out that parties proposing new projects will sometimes "game the system" by breaking projects into smaller ones to fall under the dollar threshold that triggers a CON review. This is easier in states, like Kentucky, where the threshold is quite high ($1.8 million).

In one of the few empirical studies of the relationship between CON and health care costs, Duke University researchers found that CON programs characterized as mature were associated with only a five percent reduction in per capita acute care spending (including both ambulatory and hospital care). Such CON programs did not correlate with statistically significant reductions in hospital spending (Conover and Sloan, 1998). These same authors found that elimination of the CON requirements did not result in significant increases of either new facilities or costs; indeed mature CON programs were associated with higher costs per day and per admission when compared to newer CON programs and states that had eliminated CON.

In their review of previous CON studies, Conover and Sloan (1998) also noted there is little evidence to indicate that CON has either a positive or negative impact on quality of care. It could be argued that concentrating medical care in existing facilities under a restrictive CON process could produce higher quality health care in those protected facilities because of the established relationship between high volume and quality of service, although that argument is less compelling in the present context given that the new facilities in question are (or would be) designed specifically to support high volumes of a narrow set of medical procedures. In any event, the only study to review the connection between CON and quality found that stringent CON was associated with higher mortality rates (Shortell and Hughes, 1988).

When Kansas had a CON statute, three Health Planning Agencies, located in Kansas City, Topeka and Wichita, conducted preliminary reviews of applications. These applications were then forwarded to the State with recommendations. The State office reviewed six to ten applications per month. New nursing facility beds were the most frequently requested application. Applications for new building projects or hospital beds usually took three to four months to process. Hospitals were often reluctant to share information related to new services because they did not want their competitors to know about their plans (G. Reser, personal communication, 2007).

CON application processes can be costly and time-consuming for providers. They may also disadvantage smaller hospitals that do not have staff who can be devoted to preparing the application. The process of CON has been described by many who have experienced it as overly political and not truly objective. Nevertheless, Choudry, et al. (2005) maintain that CON can be modified to allow policymakers the ability to ameliorate problems resulting from the growth of specialty hospitals, and that the financial viability of general hospitals can become a part of the certification process.

Rather than creating new CON laws, some states have taken alternative approaches to control the growth of specialty hospitals and other facilities. These states have tried to dampen the potential competitive incentives of specialty hospitals. For example, an annual tax of 3.5% of gross revenues is imposed on ASC's in New Jersey that are not owned by hospitals. The money is deposited in a Health Care Subsidy fund that is used for uncompensated hospital care. Oklahoma addresses potential inequity by requiring new specialty hospitals and ASC's to ensure that 30% of their net revenues are from services provided to Medicare or Medicaid patients. If the 30% benchmark is not reached, providers must pay a fee to the state equal to the difference between 30% of annual revenues and care for Medicare and Medicaid patients. Those fees are deposited into an uncompensated care fund. California introduced legislation that would have prohibited specialty hospitals from opening unless they operated emergency rooms that were open to all patients (Choudry, et al. 2005).

Some states considered legislation in recent years to limit the development of specialty hospitals and the expansion of ASC's. All of the following initiatives failed:

- Massachusetts, 2003, SB 641, HB 1860 - reintroduction of CON requirements for new hospitals.
- Indiana, 2004, SB 462, HB 1346 - establish a moratorium on construction of all hospitals, ASC's, and health facilities until 2006.
- Mississippi, 2004, HB 1024, SB 2782 - establish a moratorium on construction of new specialty hospitals.
- Missouri, 2005, SB 316 - establish a moratorium on construction of new specialty hospitals.

Two states have enacted legislation restricting growth:

- Montana, 2005, SB 440 - moratorium on the construction of specialty hospitals until July 2006.
- Washington, 2005, SB 5178 - moratorium on construction of specialty hospitals until July 2007.

In November 2006, the Idaho Hospital Association (IHA) submitted a petition to the Board of Health and Welfare, calling for temporary suspension of hospital licensing applications until the 2007 Idaho Legislature can weigh in on the specialty hospital issue. The petition further states the IHA plans to introduce CON legislation during the 2007 session. One of the primary reasons IHA cites for taking this action is a severe nursing shortage in Idaho.12

Conversely, the Missouri legislature designated an interim committee to study that state's existing CON law. Increasing concerns have been expressed about loss of revenue from hospitals in the Kansas City area to hospitals on the Kansas side. In addition, two hospitals in the past four years have successfully sued the Missouri Health Facilities Review Committee after being denied permission to build new facilities.

Reimbursement

Hospital Payments

Many private insurers and state Medicaid programs, including Kansas, base their payments to

12 Idaho Hospital Association. (November 17, 2006). Petition submitted to Idaho Board of health and Welfare.

hospitals on the Medicare inpatient prospective payment system (IPPS). It is important to understand how that system works in order to understand a primary incentive for operating a specialty hospital.

Within the IPPS (which began in 1983), each inpatient case is paid based on the diagnosis-related group (DRG) in which it is categorized. Every DRG is assigned a payment weight that reflects the average amount of resources used to treat that DRG. The basic Medicare payment rate is adjusted by a wage index designed for the area in which the hospital is located. Adjustments are also made for hospitals who serve a disproportionate share of low-income patients and for approved teaching hospitals to help pay for graduate medical education. Finally, some cases that are unusually costly, receive additional "outlier" payments.

The standardized amounts used for the IPPS are hospital costs for Medicare patients in 1981 that have been increased each year, at a rate determined by Congress. There are two standardized amounts – for large urban area hospitals and for all other hospitals.

While the IPPS is intended to standardize payment, there exists much variability in the average relative profitability of DRG's since the system was designed assuming every hospital would serve a mix of cases that varied in relative cost and severity (MedPAC, 2005). Hospitals that perform a large number of procedures paid at a higher rate than the hospitals' costs reap higher profits. The MedPAC report found that certain cardiac and surgical – particularly orthopedic surgical – DRG's, with relative low-to-moderate severity ratings, were highly profitable:

> The current structure of the IPPS may create financial incentives to specialize in certain DRGs…
> Because coexisting medical conditions that affect severity (and cost) are known and somewhat predictable, hospitals could obtain a favorable mix that was likely to be relatively profitable if physicians had a choice of hospitals to which they could admit patients and incentives to do so.
> …substantial differences in profitability across and within DRGs may arise primarily from problems with the DRG definitions, the DRG relative weights, and the outlier policy. (MedPAC, 2005, p. 25)

Since the IPPS is a Medicare payment system, it must be changed at the federal level. The MedPAC report recommended changes that will not be implemented until 2008 or 2009, since CMS has just awarded a contract to study ways of improving how the cost of care is used to create the DRG weights. An additional contract was awarded to evaluate an alternative system of DRG's that would include adjustments for severity. CMS issued a final rule on August 2006 that will phase in some of the DRG reimbursement changes recommended by MedPAC, beginning in October 2007. 13

Since much of the income of specialty hospitals comes from Medicare payments and private payers, the Kansas Medicaid and HealthWave program is not in a position to use its hospital reimbursement methodology to affect any change in the payment incentives that have helped drive the establishment of specialty hospitals – particularly since Medicaid reimbursement is a small part of the payments received by specialty hospitals. Kansas Medicaid does, however, subsidize uncompensated care via Medicaid DSH payments, providing some measure of relief for costs hospitals might otherwise address with service lines that have been threatened by specialty

13 Federal Register, August 18, 2006.

hospitals.

Physician Payments
Most insurers, including Medicaid programs, also reimburse physician services using the Medicare physician payment system as a benchmark – either paying what Medicare does or paying some percentage of the Medicare rate. The Medicare system, known as the resource based relative value system (RBRVS) was designed to be updated periodically and to include annual increases. Neither has occurred consistently, so physicians have seen income from office services erode. This has led physicians – notably certain specialists – to look for ways to increase reimbursement.

Federal law, the Ethics in Patient Referrals Act (known as the Stark law), prohibits physicians from referring Medicare or Medicaid patients to labs which the physicians own or from which they receive compensation. This law further expands the array of health care services to which physicians cannot refer patients if the physicians have a financial investment in the services.14 There are two primary exceptions to these prohibitions. First, ASC's are excluded. Not surprisingly, a number of ASC's have been built around the country, and Medicare has developed a separate reimbursement system for them. The second exception to the Stark law is the "whole hospital exception." Physicians may not invest in hospital departments, but may invest in entire hospitals under the theory that a physician is unlikely to be able to wield as much influence over the profits of an entire hospital as he or she could wield over a department. 15

Hadley and Zuckerman (2005) point to the concurrent growth in specialty hospitals and the lack of Medicare physician rate increases as one indication of how physicians are looking for ways to augment their incomes. Others argue that even if the development of specialty hospitals was stopped, physicians would continue to push for more control over clinical decisions in hospitals, as well as to look for broader economic opportunities (Dobson and Haught, 2005). Indeed, Berenson, et al. (Berenson, Bodenheimer and Pham, 2006) note that their interviews in twelve markets with hospital administrators, insurers, and other stakeholders indicate three major drivers for the development of specialty hospitals and specialty-lines within general hospitals:

- Physicians' desire for more income
- Patients' desire to receive diagnosis and treatment in the same place from their recommending physician
- Physicians' increasing demand for control over their schedules and work conditions.

Core Issues and Arguments

Areas of Concern
The main issues of concern that have been raised in regard to specialty hospitals are physician self-referral, unequal competition, and excess capacity.

Physician Self-Referral
Most studies that have looked at the physician self-referral issue have done so with limited data. Specialty hospitals are still relatively new and sufficient data (particularly regarding physician ownership) is difficult to come by; however, much of the data available does appear to support concern about the issue.

14 42 U.S.C. § 1395nn(a)(1)(A)
15 42 U.S.C. § 1395nn(d)(3)

Because of the whole hospital exception in the Stark law, physicians may invest in specialty hospitals and can refer their patients to the hospitals they own. Critics say this leads to "cherry picking," or ensuring that less complex and more profitable patients will be referred by physician-owners to specialty hospitals:

> It seems clear that the intent of the Stark law limitations on physician self-referral has not been achieved, largely because physicians have figured out how to take advantage of the broad exception in the law for services provided by self-referral that occurs within their own practices or for services they personally provide. (Berenson, et al., 2006, p. w342)

Both a GAO report (GAO, April 2003) and the MedPAC report (MedPAC, 2005) confirm that specialty hospitals do treat patients who are less sick and more profitable. The general hospital stakeholders we spoke to agreed with this finding and reported it was happening in their communities; however, specialty hospital advocates argue that these facilities are designed for the purpose of focusing on specific procedures for patients not likely to have complications. They argue that is a legitimate business decision.

A study limited to cardiac specialty hospitals in Arizona also supports the contention that physician-owners select more profitable patients to refer to their own specialty hospitals (Mitchell, 2005). Although, this study was criticized for not being able to clearly identify self-referrals (Dobson and Haught, 2005), another recent review of physician-owned heart hospitals found that physician ownership does affect where people receive cardiac surgery (Stensland and Winter, 2006).

The report CMS was required to submit to Congress concerning specialty hospitals concluded, "…as ownership levels increase, so do the percentage of physician referrals to their owned hospitals." (Leavitt, 2005, p. 24) A draft report about the impact of specialty hospitals in Texas noted that physician-owners referred 12 percent more patients to their specialty hospitals than non-owners did. This same study found that self-referral rates were much higher for physician owners of orthopedic hospitals, and that specialty hospital patients in Texas are less sick and more likely to have private insurance than patients seen in general hospitals (Chollet, Liu, Gimm, Fahlman, Felland, Gerland, Banker, and Liebhaber, October 2006). General hospital representatives in Kansas who spoke with KHPA report that peer pressure is applied by physician-owners of specialty hospitals on non-owner physicians to refer patients to specialty hospitals.

One aspect of the physician self-referral issue is the concern that physicians' financial stake in specialty hospitals or the additional capacity for profitable procedures that specialty hospitals bring to a community, or both, may induce demand for services that may not have been needed. KHI found (Weisgrau 2006) that the volume of specific procedures in the Kansas City, Kansas area increased significantly between 1995 and 2003, with the highest increases occurring in the two-year period during which specialty hospitals entered the market. While those results do not indicate induced demand, there has been a noticeable change in the market. In Wichita there are four specialty hospitals and two general hospitals. In 1998, 1,400 heart by-pass surgeries were performed but only 650 were performed in 2003 (Fitch Ratings, September 2004). These numbers indicate that specialty hospitals in Wichita are taking market share away from general hospitals, not inducing demand. Stensland and Winter (2006), however, report that studies of physician-owners of labs, physical therapy facilities, and imaging centers tend to support the induced demand theory. Indeed, the emergence of these types of facilities in the early 1990's led to

amendment of the Stark law, prohibiting physician self-referral to them. Again, Kansas general hospital administrators confirm that this appears to be happening with imaging centers in Kansas. The recent KHI study (Weisgrau, 2006) reported some induced demand may have occurred in the Kansas City, Kansas hospitals market, but the study's design was not able to control for a potential increase in the migration of patients and physicians from Missouri (a state with a CON law) to Kansas.

Excess Capacity

Critics of specialty hospitals also argue that the entrance of these facilities into local markets creates excess capacity; however, studies do not confirm this argument. Guterman (2006) notes, in his review of the first CMS report and the MedPAC report, that specialty hospitals captured a share of the existing market from their competitors. The study in Texas confirmed, through interviews with a broad range of stakeholders, that there was little concern there about excess capacity because of population growth and increased demand for services in the overall health care market (Chollett, et al., October 2006). Berenson, Bazzoli and Au (2006) found, however, that purchasers in three areas with significant numbers of specialty hospitals – Indianapolis, Little Rock and Phoenix – believe the entrance of specialty hospitals is driving health care costs up as general hospitals raise their rates to offset business lost to specialty hospitals. Kansas general hospital administrators also shared this belief, maintaining that the total cost of care goes up where so many services are duplicated. Kansas specialty hospital stakeholders, however, state that if physicians own a hospital they have more incentive to assess the cost of new equipment or technology thereby keeping costs down. They also argue physician-owners are able to control costs better by responding more quickly, for example, in changing supply contractors.

Unequal Competition

There is at least the prospect that additional facilities could introduce some measure of price competition into hospital markets, although existing studies do not address this possibility. Historically, health care markets have exhibited a disappointing level of savings from this sort of provider competition. More common is the concern that the nature of competition brought on by the introduction of specialty hospitals into longstanding hospital markets is simply unfair. The charge of unfair competition hinges upon the traditional role of general hospitals providing the full range of services of value to a community, both profitable and unprofitable. Competition from specialty hospitals is viewed as unfair because general hospitals that provide emergency rooms and other unprofitable services do so in part by diverting revenue from profitable lines. Most specialty hospitals do not provide significant amounts of charitable care or serve many Medicaid patients. CMS (U.S. Department of Health and Human Services, 2005) found the payer mix to be very different between specialty hospitals and general hospitals:

Payer Mix		
	General hospital	**Specialty Hospital**
Medicaid	7.0%	2.3%
Medicare	31.2%	22.5%
Other sources	61.8%	75.2%

The Texas study (Chollet, et al., October 2006) confirmed the differences reported by CMS, noting 54 percent of specialty hospital patients were private pay compared to 31 percent in general

hospitals. That study also found the following differences related to Medicare and Medicaid patients:

	Specialty	General
Medicare	34%	41%
Medicaid	3%	19%

Specialty hospitals focus on specific lines of business and do not provide unprofitable services. For example, orthopedic/surgery hospitals usually have no emergency departments and, while they may have a small number of inpatient beds, those beds are rarely filled. By contrast, cardiac hospitals more closely resemble general hospitals because the nature of the procedures performed in them is more likely to require an inpatient stay (Leavitt, 2006). The KHI study (Weisgrau, 2006) found that one-third of the specialty hospitals in Kansas billed a single DRG for more than two-thirds of their patients.

General hospital administrators, including the ones we spoke with, are also concerned about losing specialists who may no longer be willing to serve "on call" at emergency departments. This can result in more emergency cases being transferred to hospitals farther away. Meanwhile, many specialty hospitals are free of the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements since they choose not to provide emergency departments (Choudry, et al., 2005). Kansas general hospital stakeholders express worry that workforce shortages are worsening, especially in anesthesiology, due to the proliferation of facilities. This is a challenge to the general hospitals' ability to provide 24-hour care, seven days a week. One general hospital administrator stated, "We've become the training ground for specialty hospital staff." Although there are not significant pay differences for nurses, for example, specialty hospitals can provide more amenable work schedules.

Financial Impact

In a report produced for the Wyoming Health Care Commission (Fahlman, Felland, Banker, Liebhaber, Chollet, Gimm, and Taylor, 2006), researchers noted that national studies demonstrate specialty hospitals do not negatively affect the overall financial performance of general hospitals. KHI's study came to the same conclusion in its empirical review of the financial impact of specialty hospitals on general hospitals in Kansas. Although it is difficult to understand how facilities of this type could enter a market, command a significant share of high-volume, high-profit procedures in that market, and yet not do damage to the bottom lines of competing general hospitals, that is the conclusion to be drawn from available studies. This may be due, in part, to actions general hospitals have taken to modify their pricing structure or business practices, e.g. reducing staff, eliminating unprofitable services, or developing their own specialty services.

The rise of specialty hospitals has refueled debate about how to finance health care. While many argue that competition ultimately promotes better and/or cheaper care to the patient, general hospitals may be limited in their ability to compete because of the demands placed on them by their community oriented mission — and by government mandates. Dummit points out that communities and government expect general hospitals "to meet surges in demand during flu season or to respond to a natural disaster or terrorist event. This stand-by capacity adds to the costs of these facilities, making it harder for them to be competitive." (Dummitt, 2005) A fundamental question is how this capacity and other unprofitable community–oriented hospital services should be paid for when specialty hospitals threaten the market power general hospitals have relied on to generate revenue.

In a report to Congress, the Centers for Medicare and Medicaid Services (CMS) pointed out that because for-profit facilities pay taxes, while not-for-profit hospitals are exempt, the "net community benefit" compared to the sum of uncompensated care and tax payments as a portion of net revenue, is higher in specialty hospitals than in general hospitals (MedPAC, 2005). However, these additional tax revenues generated from patient care largely diverted away from community hospitals have not been captured by Federal nor State governments to address community health care costs that general hospitals say are threatened by the loss of profitable business. Physician owners, specialty hospital administrators and supporters cite the CMS study to support the argument that they provide financial contributions to the local community, albeit differently than general hospitals.

Potential Advantages

While the introduction of specialty hospitals into health care markets in Kansas has raised a number of potentially troubling concerns, these facilities may also present a number of advantages.

Increased Physician Control and Earnings

Many specialty hospital physician-owners indicate they are very pleased with the structure of specialty hospital arrangements, reporting they exercise more control over their surgical schedules than they do in general hospitals. In a specialty hospital, there are fewer surgeons to rotate between operating rooms. Physician owners in specialty hospitals may schedule multiple procedures back to back without having to wait hours at a time between procedures as they do in the general hospital. The physical layout of specialty hospitals is also designed to meet the needs of the physicians, making their procedures more convenient and efficient for them to perform.

Physicians also earn more income than in the general hospital alone, by virtue of having more control over surgical schedules. Specialty hospital administrators in smaller markets have asserted that this added earnings potential makes it easier to recruit specialists to their communities. The MedPAC (2005) report noted that "specialty facilities offer financial incentives for physicians and produce more efficient operations with higher-quality outcomes than general community hospitals." (p. vii) Physician-owners also note there is less bureaucracy, and appreciate the fact they are not required to be "on-call" at a specialty hospital. Specialty hospital supporters say they address unmet needs in their communities, and serve as a wake up call to general hospitals, indicating that they need to be responsive to both patients and physicians to remain viable (Dummit, 2005). Kansas specialty hospital stakeholders reported that many of their physician-owners talked with general hospitals about partnerships, but their perception was that general hospitals were not responsive to increased governance by physicians.

Potential for Higher Quality

Some suggest the potential for these facilities to offer higher quality services, higher patient satisfaction, and lower costs. Based in the demonstrated linkage between the volume and quality of care in a facility, there is a reasonable expectation that an increase in the concentration of procedures or treatments in a smaller number of facilities – as might occur with the introduction of a specialty hospital into a hospital market – would lead to a higher overall level of quality.16 Some believe that specialty hospitals result in better patient care and outcomes because physician-

16 Quality studies reviewed for this report compared outcomes of care in general and specialty hospitals, but did not address the impact of competition on the overall level of quality in the market.

owners participate more directly in management decisions. It has also been suggested that "care in such facilities is organized along product lines or by type of illness, and economies of scale could occur and result in lower production costs." (Mitchell, 2005, w5482) Choudry et. al (2005) note the American Surgical Hospital Association (ASHA) argument that specialty hospitals "…improve patient satisfaction by:

- "providing patient centered care
- "simplifying bureaucracy
- "improving outcomes
- "focusing on a narrow range of procedures performed in higher volumes lowering costs and expanding access through economic efficiencies..."

Specialty hospitals have fewer patients than general hospitals. Because of the increased nurse to patient ratio, nurses are readily available to be more responsive to patient needs. Patients therefore perceive they are receiving more individualized and better care. If nurses can provide more attention for each patient, patients may experience shorter lengths of stay and improved patient outcomes. (MedPAC, 2005)

High Patient Satisfaction

Physician-owners of specialty hospitals frequently point to high patient satisfaction as an indicator of the support of their facilities. These facilities' small size and narrower purpose may make it easier to accommodate both care and comfort. During KHPA visits to Kansas specialty hospitals, we observed quiet environments and comfortable rooms in which patients could recover. Following a surgical procedure, patients may return to their room, often located just feet from the operating room, rather than moving to a recovery room, then returning to their room. Family members may follow them, and expect to find comfortable furnishings available while they wait for the patient to recover. If patients do not have to be moved about the facility during their recovery, continuity of nursing care can be increased.

Wider Impact on Hospital Markets

The direct effect of specialty hospitals on general hospitals has not been established, but many general hospitals are making changes, and some admit it is because of the entrance of specialty hospitals in their markets (MedPAC, 2005). Specialty hospitals are only part of the competition general hospitals face. ASC's and imaging centers are proliferating, as well, and will continue to challenge the financial well-being of general hospitals. Fitch Ratings (September 2004) notes that ASC's may exert a greater impact on general hospitals, over time, than specialty hospitals. The most recent GAO report found that general hospitals are making changes whether or not specialty hospitals are entering their areas. The survey data collected for that report did not support the idea that specialty hospitals were the impetus for general hospitals to become more efficient (GAO, 2006).

Whether or not competition has been driving changes in hospital markets, a joint report produced by the Federal Trade Commission and the Department of Justice (July 2004) offers this caution:

> Competition cannot provide its full benefits to consumers without good information and properly aligned incentives. Moreover, competition cannot eliminate the inherent uncertainties in health care, or the informational asymmetries among consumers, providers, and payors. Competition will also not shift resources to those who do not have them.

Conclusions and Recommendations

Conclusions

Much of the growth in specialty hospitals can be attributed to flaws in hospital payment schedules, which provide overly generous rewards for certain procedures and product lines. In this respect, the key forces driving development of specialty hospitals in Kansas are beyond the control of the State. Reimbursement for both hospitals and physicians must change within the Medicare program. HHS/CMS has proceeded with some changes to the IPPS, but the changes will not be fully implemented for some time. Physician reimbursement in Medicare continues to be a battleground, with reductions being proposed, then failing to pass in Congress. MedPAC recently proposed a 1.7 percent increase for 2007. One reason these reforms are so difficult to enact politically is that current Medicare payment imbalances favor a number of general hospitals around the country, just as they favor specialty hospitals in Kansas.

The question of self-referral relates directly to these flaws in payments for hospital services. If payments could be designed that adjust perfectly for variations in the severity and complexity of each medical case, then physician-owners of specialty hospitals would receive no reward for diverting more costly cases to full service hospitals. If payments could be withheld for cases in which surgery was unwarranted, then physician-owners would receive no reward for over-prescribing costly hospital based procedures. Unfortunately, payment systems are not sophisticated enough – and may never able – to remove completely the financial reward to physician-owners for diverting costly patients and over-prescribing procedures. This suggests the potential value of regulating referrals by physician-owners. Such regulation may also carry a cost in that the same financial incentives that threaten an appropriate physician-patient relationship may also suppress physicians' incentives to initiate and support cost-saving measures in a general hospital. The differences observed in the referral patterns of physician-owners and non-owners is consistent with the unwanted incentives associated with self-referral. However, the net impact of physician ownership and self-referral on overall costs and patient care has not yet been firmly established.

The Stark self-referral law containing the whole hospital physician ownership exception is a federal law affecting Medicare reimbursement, and can only be changed by Congress. With a change in Congressional leadership this session, it is possible the whole hospital exception will be re-visited. If this exception is removed, it will prohibit Medicare reimbursement for physician self-referrals, which would effectively end physician investment in specialty hospitals. If Congress does not act to address the whole hospital exception, and especially if it does not also address the flaws in Medicare hospital payments for specialty services, the state of Kansas should consider addressing the issue of self-referral itself, e.g., through regulatory restrictions or hospital licensure requirements.

Most general hospital administrators we met with were pessimistic that anything short of a moratorium on specialty hospitals would address their concerns about loss of business and ability to provide necessary services 24 hours a day. While the loss of business to specialty hospitals is apparent, studies addressing this question have not yet revealed a negative impact on general hospital operating margins. Alternatively, specialty hospital administrators argue they are a natural result of physician dissatisfaction with general hospitals. They urge letting market forces determine where and how health care is provided. Although the measured impact on health outcomes has been modest, studies have shown a positive impact on patient care. The tension between physician specialists who own and work at specialty hospitals and general hospitals is not

new. A similar situation existed in the 1950's when many physicians were involved in developing for-profit hospitals (Light, 2004). Neither group appears to support fully the reintroduction of CON in Kansas. General hospitals believe it is too late and that CON would only hurt them. Specialty hospitals repeat their argument that market forces, not government regulation, should drive investment and expansion in health facilities.

A fundamental issue is what role should be played by general hospitals, and how government should subsidize unprofitable services that are beneficial to the community. This subsidization occurs in Kansas with disproportionate share hospital (DSH) payments and semi-annual Medicaid access payments made from hospital provider assessment funds, both of which provide supplemental payments that specialty hospitals do not qualify for. However these mechanisms are not designed to compensate for the targeted competition that specialty hospitals have introduced in certain markets.

Recommendations

Existing evidence does not clearly indicate whether the harm that specialty hospitals may do to general hospitals and the community services they provide outweighs the value specialty hospitals may add to patient quality and competition. State interventions to protect hospital markets and to correctly align physician incentives might best be addressed after the new Congress has a chance to address flaws in Medicare physician and hospital payments. Nevertheless, the potential impact of specialty hospitals is important enough to merit continued attention. The KHPA Board has adopted vision principles calling for access to high quality, affordable, patient-centered care. In light of the concerns and promise associated with the introduction of specialty hospitals into health care markets in Kansas, KHPA recommends the following:

1. Specialty hospitals have affected the market share of general hospitals and have taken advantage of flaws in hospital payments to generate significant profits. Recently announced changes to the Medicare IPPS will help address concerns about the relative profitability of services provided in general and specialty hospitals. KHPA should incorporate these changes into its Medicaid inpatient reimbursement rates.

2. Although a negative financial impact of specialty hospitals on general hospitals has not yet been demonstrated, specialty hospitals have taken important market share from general hospitals. In an effort to provide a more transparent system for the funding of hospital services that benefit the community, such as uncompensated care for the uninsured, KHPA should continue its work with hospitals to re-design the Medicaid DSH program to provide a more consistent and better-targeted source of funding for uncompensated care.

3. The harm and/or benefit of specialty hospitals may emerge in greater clarity as time goes on. To monitor the potential impact of specialty hospitals and other facilities on the quality and cost of care in Kansas, data to support ongoing analysis of this impact should be collected and maintained by KHPA. This imperative is also consistent with KHPA's statutory charge to develop and track key health indicators. To support this need, all Kansas hospitals should (continue to) provide information such as that contained in KHA's hospital discharge database, including payment information and patient diagnoses, to KHPA. With appropriate staffing, KHPA plans to implement this recommendation through policies developed by the Data Consortium, a collection of stakeholders and data users that will advise the Board on matters of data collection

and use (see Appendix B).

4. The potential benefits of specialty hospitals are predicated on the existence of a more competitive and informed marketplace. Competition is most likely to improve overall patient quality if patients are free to make informed choices about their providers. KHPA has recommended a two-phase initiative to provide greater health information transparency for consumers by i) working with Kansas libraries to create a common destination for publicly-available sources of information on health care costs and quality, and ii) working through the Data Consortium to generate new sources of information that can be collated and shared with consumers.

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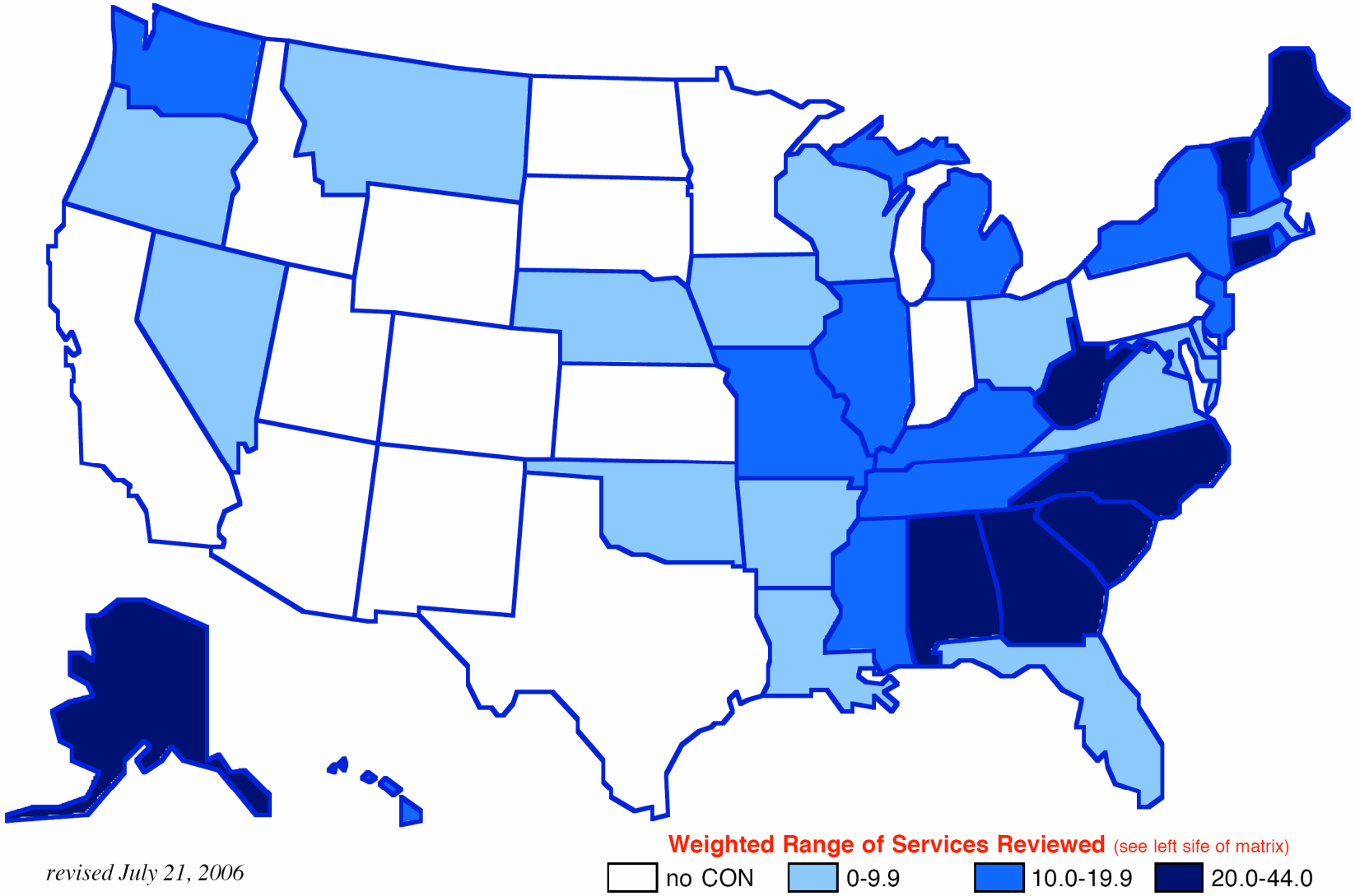
Appendix A
Certificate of Need Programs

a Map of the
2006 Relative Scope and Review Thresholds: CON Regulation by State
(a geographic illustration of the CON matrix)



revised July 21, 2006

The CON Matrix of
2006 Relative Scope and Review Thresholds: CON Regulated Services by State

(summarized from the 2006 National Directory of State Certificate of Need Programs and Health Planning Agencies, the 17th edition published by the American Health Planning Association, also see map)

compiled by ***Thomas R. Piper***
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Rank (no. of svcs. x weight)	Categories	Acute Care	Air Ambuance	Amb Surg Ctrs	Burn Care	Business Cmptrs	Cardiac Cath.	CT Scanners	Gamma Knives	Home Hlth	Hospice	ICF/MR	LTC Hospital	Lithotripsy	Long Term Care	Med Off Bldg	Mobile Hi Tech	MRI Scnrs	Neo-ntl Int Care	Obstetric Svcs	Open Heart Svcs	Orgn Transplnt	PET Scnrs (incl CT)	Psychiatric Svcs	Rad Therapy	Rehabilitation	Renal Dialysis	Asst Lvg/RCF	Subacute	Substance Abuse	Swing Beds	Ultra-sound	Other (items not otherwise covered)	Tally (no. of svcs.)	ReviewabilityThresholds Capital	Med Eqpt	New Svc	Weight
33.6	Connecticut	■	■	■	■	■	■	■	■		■		■	■	■	■	■	■	■	■	■	■	■	■	■	■		■		■	■	■	Others	28	1,000,000	400,000	0	1.2
29.7	Vermont	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■			■	■			27	3,000,000	1,000,000	500,000	1.1
29.0	Alaska	■	■	■	■		■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	Assisted living	29	1,050,000	1,050,000	1,050,000	1.0
28.6	Georgia	■		■			■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■		DTRCs	26	1,483,083	823,934	any amt	1.1
25.2	West Virginia	■		■		■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■		Behavioral hlth	28	2,000,000	2,000,000	any amt	0.9
24.0	Maine	■		■	1		■	■	■			■	■	■	■		■	■	■	■	■	■	■	■	■	■	■			■	■	■		24	2,666,198	1,333,099	112,800	1.0
21.6	North Carolina	■	■	■	■		■	■	■	■	■	■	■	■	■		■	■		■	■	■	■	■	■	■	■	■		■	■	■	IC & others	27	2,000,000	750,000	0	0.8
20.0	Mississippi	■		■			■		■	■	■	■	■	■	■			■		■		■	■	■	■	■	■	■		■	■			20	2,000,000	1,500,000	any amt	1.0
20.0	South Carolina	■		■			■		■	■		■	■	■	■		■	■	■	■	■		■	■	■	■			■	■				20	2,000,000	600,000	1,000,000	1.0
17.6	Tennessee	■	■	■			■	■		■	■	■	■	■	■			■	■		■		■	■	■	■			■	■	■		Other	22	2,000,000	1,500,000	any beds	0.8
16.8	Dist. of Columbia	■		■	■		■	■	■	■			■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■			24	2,500,000	1,500,000	600,000	0.7
16.2	New York	■		■			■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		27	3,000,000	3,000,000	any amt	0.6
16.0	Kentucky	■		■			■			■	■	■	■	■	■		■	■	■		■	■		■	■	■		■	■				Mobile svcs	20	1,951,612	1,951,612	n/a	0.8
16.0	Rhode Island	■		■			■	■	■				■		■		■	■	■	■	■	■	■	■	■	■			■	■	■			20	2,000,000	1,000,000	750,000	0.8
16.0	Missouri	■					■	■	■			■	■	■	■		■	■		■		■		■		■	■	■					New hosp.	16	1,000,000	1,000,000	1,000,000	1.0
15.6	Hawaii	■	■	■	■		■	■	■	■		■	■	■	■		■	■	■	■	■	■	■	■	■	■	■		■	■	■			26	4,000,000	1,000,000	any amt	0.6
15.2	Michigan	■	■	■			■	■	■				■	■	■		■	■	■		■	■	■	■	■							■	Hosp & Surg	19	2,715,000	any amt	any clinicl	0.8
15.0	New Hampshire	■		■			■	■					■	■	■		■	■		■		■	■	■	■				■					15	2,150,891	400,000	any amt	1.0
14.3	New Jersey	■			■		■			■		■	■		■				■		■	■		■		■		■						13	1,000,000	1,000,000	any amt	1.1
13.2	Alabama	■		■			■		■	■	■		■	■	■			■	■	■	■	■	■	■	■	■	■			■	■	■	ESRD & ALC	22	4,251,780	2,125,890	any amt	0.6
11.9	Washington	■		■	■		■			■	■		■		■				■	■	■	■				■	■		■		■	■	New hosp bds	17	1,000,000	n/a	any amt	0.7
10.8	Arkansas									■	■	■	■		■													■			■	■	Others	9	500,000	n/a	n/a	1.2
9.0	Iowa			■			■					■	■		■						■	■	■		■									9	1,500,000	1,500,000	500,000	1.0
8.4	Illinois	■		■	■		■		■		■	■	■		■				■	■	■	■	■	■	■	■	■		■		■		Other	21	7,167,063	6,575,036	any amt	0.4
8.4	Virginia	■		■			■	■	■			■	■	■	■		■	■	■	■	■	■	■	■	■	■				■			MSI, SPECT	21	5,000,000	lstd eqpt	lstd svc	0.4
8.4	Florida	■			■						■	■	■		■				■		■	■		■						■				12	n/a	n/a	n/a	0.7
7.8	Oklahoma											■			■									■						■			psych.	6	500,000	n/a	any beds	1.3
6.3	Montana			■						■		■			■											■				■	■			7	1,500,000	n/a	150,000	0.9
5.7	Maryland	■		■	■		■			■	■	■	■		■				■	■	■	■		■	■	■				■	■		Others	19	10,000,000	n/a	5,000,000	0.3
5.4	Delaware	■		■			■						■	■	■								■	■	■								Birthing ctrs.	9	5,000,000	5,000,000	n/a	0.6
5.1	Massachusetts		■	■					■				■	■	■		■	■		■	■	■	■	■	■	■		■		■			ECMO	17	12,516,300	1,335,072	any amt	0.3
4.5	Nevada	■		■							■	■	■		■											■				■	■			9	2,000,000	n/a	n/a	0.5
4.4	Wisconsin											■			■															■			Others	4	1,000,000	600,000	any LTC	1.1
2.4	Oregon														■																■			2	anyLTC/hsp	n/a	LTC/hsp	1.2
1.0	Ohio										■				■																			2	2,000,000	n/a	n/a	0.5
0.4	Nebraska														■											■								2	any LTC	n/a	n/a	0.2
0.4	Louisiana											■			■																			2	n/a	n/a	LTC/MR	0.2

Disclaimer: Rank order relates to volume of items reviewed, NOT intensity of analysis or conclusions which are based on Criteria and Standards and decisions

Source: Updated July 21, 2006, using most recent information available

Kansas Health Policy Authority
Coordinating health & health care for a thriving Kansas

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Appendix B
Data Consortium Draft Charter

Charter Statement for the Kansas Health Policy Authority Data Consortium

In its enabling legislation, the Authority is given responsibility for a wide range of health and health care data and is charged with using and reporting that information and to increase the quality, efficiency and effectiveness of health services and public health programs. The Authority is specifically required to adopt health indicators and include baseline and trend data on health costs and indicators in each annual report submitted to the Legislature. The Authority also bears statutory responsibility for managing a wide array of health data that includes both programmatic, or administrative, information and non-programmatic data:

> *Programmatic data.* Beginning July 1, 2006 the Authority will also be responsible for using and managing the programmatic data associated with Medicaid, the state employees health benefits plan, and the state workers compensation self-insurance fund.
>
> *Non-programmatic* data. The legislation establishing the Authority transferred powers and responsibilities of the Health Care Data Governing Board effective January 1, 2006, including ownership of the health care data system. The health care data system includes inpatient hospital claims information and the provider database. The Authority is also empowered to expand or redefine data submission requirements by providers, insurers, and others. House Bill 3010, under consideration by the 2006 state legislature, would transfer responsibility for management of the Kansas Health Insurance Information System (KHIIS) to the Kansas Health Policy Authority. Since ownership of the KHIIS remains with the Kansas Insurance Department, final decisions regarding the collection and use of this data would rest with the Commissioner.

Establishment. Meeting the information challenge will require a new direction, additional resources, and a coordinated partnership between the Kansas Health Policy Authority and the wide community of stakeholders with an interest in the appropriate and effective use and dissemination of health data. To help meet this broad set of responsibilities, the Kansas Health Policy Authority Board hereby establishes a Data Consortium.

Charge. The Kansas Health Policy Authority is to ensure the effective collection, management, use and dissemination of health care data to improve decision-making in the design and financing of health care and public health and wellness policies. To help meet the Authority's responsibilities in this area, the Executive Director is charged with the responsibility of convening and directing the Data Consortium. The Consortium is to advise the Authority in the development of policies and bring recommendations to the Authority for consideration. Specific responsibilities of the Data Consortium include:

- making recommendations regarding the scope of the Authority's responsibilities for managing health data;
- recommending reporting standards and requirements for non-programmatic data owned or managed by the Authority;

- crafting data use policy recommendations governing access to health information by external users of both programmatic and non-programmatic data owned or managed by the Authority;
- recommending empirical studies and evaluations supporting the goals and objectives of the Authority;
- providing input on health and health care data initiatives in other organizations and agencies;
- developing recommendations for public reporting standards for health care providers and other health care organizations.

Membership. The Data Consortium is designed to bring together those who generate, manage and use health data in order to ensure that data policies and recommendations are developed with the widest possible consideration. Consortium membership is determined by the Authority and will include the following individuals and representatives from the following organizations:

Executive Director of the Health Policy Authority
Department of Health and Environment
Department of Social and Rehabilitation Services
Kansas Insurance Department
University of Kansas Medical Center
University of Kansas Medical Center-Wichita
Kansas Health Institute
Kansas Foundation for Medical Care
Kansas Medical Society
Kansas Hospital Association
Kansas Association of Osteopathic Medicine
Kansas Mental Health Association
Kansas Association for the Medically Underserved
Kansas Nurses Association
AARP
Kansas Public Health Association
Two self-insured employers appointed by Kansas Chamber of Commerce and Industry

Governance. The Health Authority establishes the Data Consortium as an advisory committee to the Authority according to section 3(c) of Senate Bill 272. The Board authorizes the Consortium and as many as three working sub-groups of the Consortium to meet as many as six times each year. The scope of responsibility granted to the Data Consortium by the Health Authority is defined in this charter statement, but may be revised by the Authority at its discretion. The Executive Director will serve as Chair of the Consortium. Unless alternative procedures are adopted by the Consortium, formal decisions and recommendations of the Consortium are to be deliberated according to Robert's Rules of Order.

The Board recognizes the wide range of issues and responsibilities that will be brought together under the aegis of the Consortium. To help meet these potentially diverse responsibilities, the Board recommends the establishment of working groups (or consortia) in three specific areas operating within the Data Consortium to develop health care policy and data recommendations for the Board: (1) Health Care Quality; (2) Health Care Pricing; and (3) Public Health/Consumer information.

Staff support. The Executive Director of the Health Authority is responsible for the provision of staff to support the activities of the Consortium. The Consortium is formed to help meet the Authority's statutory requirements in the area of data policy and management. These requirements are substantial, and will require additional resources if the Consortium and the Authority are to meet their objectives in these areas. The Board in its first report to the legislature on March 1, 2006 indicated that it would develop a request for additional resources to address data management and analytic needs. This request will enable the Authority to address the full intent of this Charter statement as well as the broad statutory expectations for the Authority.